FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0015032

Facility Name: Washington And Jane Smith

Address: 2340 W 113Th Place (Number) Chicago (City) 60643 (Zip Code)

County: Cook

Telephone Number: (773) 779-8010 **Fax #** (773) 779-8648

IDPA ID Number: 362167948001

Date of Initial License for Current Owners:

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/02 to 06/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Richard S. Sgarlata, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Date: **07/01/2003**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2003 Long Term Care Cost Report and Instructions on Diskette

Enclosed you will find a copy of the 2003 cost report and instructions on diskette. Please complete your 2003 cost report using this diskette. When you have completed the cost report, **please send in the diskette along with the paper copy of your cost report and all attachments**.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2003. It is due on September 30, 2003, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There is one 2003 cost report file on the disk you have received. The file has been created for use with Excel 97 or 2000. A copy of the 2003 cost report instructions has been included on the diskette also. The name of the file is Instr03.pdf. It has been created for use with Adobe Acrobat Reader. Please use this 2003 diskette. **Printed copies of the report from the 2002 cost report diskette or earlier diskettes will NOT be accepted.** In order to print the instructions on legal paper, open the Instr03.pdf file. Then click File-Page Setup. Then, change the paper size to legal and click OK. Otherwise, the instructions will print on letter size paper. The type may be a little small if letter size is used.

IMPORTANT NOTICE for Those facilities Receiving a Calendar 2002 Real Estate Tax Bill
Located after page 10 of the cost report on the worksheet named "RE_TAX" is the "2002 Long Term Care Real Estate Tax Statement". This year the real estate tax statement is being included in the cost report. **A separate notice requesting the submittal of this statement and the calendar 2002 tax bill will not be sent**. Please complete the "2002 Long Term Care Real Estate Tax Statement" and send it to our office along with the copies of the calendar 2002 real estate tax bills **at the same time you submit the fiscal 2003 cost report**.

If both the "2002 Long Term Care Real Estate Tax Statement" and the corresponding tax bills are not included with the 2003 cost report, the Medicaid rate will not include a component for real estate taxes. Additionally, the cost report will not be considered complete and timely filed and may be subject to Medicaid payments being withheld.

Cost Report File
Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (**Be sure to enter the IDPH licensed name of the facility. Ensure that the 7 digit IDPH ID# is correct.) When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12, do not enter "various" or other text in columns 2 or 3.**

Attachments
Please include all explanations, additional details and additional schedules, including the information for owners' compensation, on the worksheets in the cost report file. Separate worksheets have been included after page 23 for the recording of this type of detail. Additionally, you may also insert these sheets in the file behind the pages to which they correspond. Please do not change the sheet names of pages 1 through 23, ReadMe or Macro. Also, do not change any range names or range references.

Page 12 and Pages 12A through 12I
Pages 12A through 12I have been set up to carry forward the totals from the previous page 12. For example, if you use pages 12 through 12F, the total on page 12F will be your grand total building and improvements cost. Only the pages that you use will be printed when the "Print Entire Report" macro is selected. (**Note**: Page 12 - In previous years, line 36 was the total of lines 4-35. For the 2002 and 2003 cost reports, lines 4-69 will total on line 70. Line 36 can now be used to list building improvements.)

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

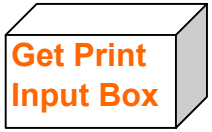
As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to the Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Cost Report File and Extra Pages
The entire cost report is in one file named Report03.xls. In an Excel 97 or 2000 file that has been sealed, you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw



Shortcut=
Hold down
Control Key and press m

Shortcut=
Hold down
Control Key and press q

To Stop Macro:
Hold down
Control Key and press "Break"

IF YOU WOULD LIKE THE NOTE, " SEE ACCOUNTANTS' COMPILATION REPORT" AT THE BOTTOM OF EVERY PAGE, ENTER THE NUMBER 1 IN CELL E4.

1

If you would like Pages Summary A and Summary B to print, change cell E11 to zero.

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	94	Skilled (SNF)	94	34,310	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	185	Sheltered Care (SC)	185	67,525	5
6		ICF/DD 16 or Less			6
7	279	TOTALS	279	101,835	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,339	18,039	2,539	30,917	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	6,456	36,053		42,509	12
13	DD 16 OR LESS					13
14	TOTALS	16,795	54,092	2,539	73,426	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.10%

D. How many bed-hold days during this year were paid by Public Aid?
N/A (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/25/26

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 15 and days of care provided 2,500

Medicare Intermediary Adminastar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/03 Fiscal Year: 06/30/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	492,493	2,620		495,113		495,113	(2,671)	492,442			1
2	Food Purchase		698,782		698,782		698,782		698,782			2
3	Housekeeping	133,684	48,041		181,725		181,725		181,725			3
4	Laundry	80,428	16,080		96,508		96,508		96,508			4
5	Heat and Other Utilities			334,320	334,320		334,320	(25,635)	308,685			5
6	Maintenance	351,398	13,912	205,439	570,749		570,749	(37,157)	533,592			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,058,003	779,435	539,759	2,377,197		2,377,197	(65,463)	2,311,734			8
	B. Health Care and Programs											
9	Medical Director			11,600	11,600		11,600		11,600			9
10	Nursing and Medical Records	2,380,401	108,624	58,531	2,547,556		2,547,556	(11,432)	2,536,124			10
10a	Therapy	77,852		2,966	80,818		80,818		80,818			10a
11	Activities	230,470	36,298	36,409	303,177		303,177		303,177			11
12	Social Services	129,846	1,793	4,492	136,131		136,131		136,131			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,818,569	146,715	113,998	3,079,282		3,079,282	(11,432)	3,067,850			16
	C. General Administration											
17	Administrative	140,642			140,642		140,642		140,642			17
18	Directors Fees											18
19	Professional Services			168,541	168,541		168,541	(63,836)	104,705			19
20	Dues, Fees, Subscriptions & Promotions			15,821	15,821		15,821	(8,114)	7,707			20
21	Clerical & General Office Expenses	422,614	52,554	421,087	896,255		896,255	(379,016)	517,239			21
22	Employee Benefits & Payroll Taxes			1,130,193	1,130,193		1,130,193		1,130,193			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,849	5,849		5,849	(40)	5,809			24
25	Other Admin. Staff Transportation			71	71		71		71			25
26	Insurance-Prop.Liab.Malpractice			122,352	122,352		122,352		122,352			26
27	Other (specify):*											27
28	**TOTAL General Administration**	563,256	52,554	1,863,914	2,479,724		2,479,724	(451,006)	2,028,718			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,439,828	978,704	2,517,671	7,936,203		7,936,203	(527,901)	7,408,302			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Washington And Jane Smith #0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			516,162	516,162		516,162	(17,509)	498,653			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			179,477	179,477		179,477	(9,898)	169,579			32
33	Real Estate Taxes			3,522	3,522		3,522	(3,522)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			40,254	40,254		40,254		40,254			35
36	Other (specify):*			7,416	7,416		7,416		7,416			36
37	**TOTAL Ownership**			746,831	746,831		746,831	(30,929)	715,902			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		608,477	280,642	889,119		889,119		889,119			39
40	Barber and Beauty Shops			48,292	48,292		48,292	(43,226)	5,066			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,465	51,465		51,465		51,465			42
43	Other (specify):*	117,249		33,948	151,197		151,197	(151,197)				43
44	**TOTAL Special Cost Centers**	117,249	608,477	414,347	1,140,073		1,140,073	(194,423)	945,650			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,557,077	1,587,181	3,678,849	9,823,107		9,823,107	(753,253)	9,069,854			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,671)	1		4
5	Telephone, TV & Radio in Resident Rooms	(404)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	16,448	30		9
10	Interest and Other Investment Income	(1,722)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(4,425)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(337,356)	21		24
25	Fund Raising, Advertising and Promotional	(5,801)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(516)	20		28
29	Other-Attach Schedule	(416,806)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (753,253)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (753,253)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Washington And Jane Smith

ID# 0015032

Report Period Beginning: 07/01/02

Ending: 06/30/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	OTHER INCOME - DISCOUNTS EARNED	$ (2,886)	21	1
2	RESIDENT TRANSPORT	(8,959)	06	2
3	MISCELLANEOUS RESIDENT CHARGES	(29)	21	3
4	GUEST ROOM INCOME	(1,717)	06	4
5	REFUNDS & REBATES	(4,743)	21	5
6	DISCOUNTS EARNED	(3,964)	21	6
7	FLOWERS	(2,822)	21	7
8	INVESTMENT ADVISORY FEE	(55,556)	19	8
9	APT. PROPERY TAXES	(3,522)	33	9
10	PODIATRY EXPENSE	(11,432)	10	10
11	BLDG & GR APT - SUPPLIES GENERAL	(521)	43	11
12	BLDG & GR APT - YARD MAINT	(840)	43	12
13	BLDG & GR APT - REP & MT-EQUI	(1,250)	43	13
14	BLDG & GR APT - R&M PAINT	(450)	43	14
15	BLDG & GR APT - PLUMBING	(601)	43	15
16	BLDG & GR APT -R&M BLDG	(1,724)	43	16
17	APT - INTEREST ON SECURITY DEPOSIT	(87)	43	17
18	BLDG & GR APT - REFUSE DISPOSAL	(2,027)	43	18
19	APT - HEAT POWER -UTILITIES GAS	(9,143)	43	19
20	APT - HEAT POWER -ELECTRICITY	(2,142)	43	20
21	APT - HEAT POWER - WATER	(1,803)	43	21
22	CABLE TV	(25,635)	05	22
23	MISCELLANEOUS	(50)	21	23
24	MISC BOND EXP	(23,129)	21	24
25	BOND INTEREST - APT	(8,176)	32	25
26	LOC FEES - APT	(4,790)	43	26
27	MISC BOND EXP - APT	(2,237)	43	27
28	DEPRECIATION - APT	(33,957)	30	28
29	OUT OF STATE SEMINAR	(40)	24	29
30	R&M CAPITALIZED	(26,481)	06	30
31	OUT OF PERIOD LEGAL FEES	(1,835)	19	31
32	BARBER AND BEAUTY INCOME	(43,226)	40	32
33	COMMUNITY RELATIONS SALARY	(117,149)	43	33
34	ASSISTED LIVING - AGENCY	(6,323)	43	34
35	PROMOTIONS	(1,797)	20	35
36	NON CARE RELATED LEGAL FEES	(5,845)	19	36
37	APPRAISAL FEES	(600)	19	37
38				38
39				39
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100				100
101	**Total**	(416,806)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Washington And Jane Smith # 0015032 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(2,671)											(2,671)	1
2	Food Purchase													2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(25,635)											(25,635)	5
6	Maintenance	(37,157)											(37,157)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(65,463)											(65,463)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(11,432)											(11,432)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(11,432)											(11,432)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(63,836)											(63,836)	19
20	Fees, Subscriptions & Promotions	(8,114)											(8,114)	20
21	Clerical & General Office Expenses	(379,016)											(379,016)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(40)											(40)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	**TOTAL General Administration**	(451,006)											(451,006)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(527,901)											(527,901)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Washington And Jane Smith** **#** **0015032** **Report Period Beginning:** **07/01/02** **Ending:** **06/30/03**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	**(17,509)**											**(17,509)**	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	**(9,898)**											**(9,898)**	32
33	Real Estate Taxes	**(3,522)**											**(3,522)**	33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	**(30,929)**											**(30,929)**	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops	**(43,226)**											**(43,226)**	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	**(151,197)**											**(151,197)**	43
44	**TOTAL Special Cost Centers**	**(194,423)**											**(194,423)**	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(753,253)**											**(753,253)**	45

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Investment	$ 55,556	Heritage Capital		$ 55,556	$	1
2	V	26	Insurance	122,352	The Orthon Group		122,352		2
3	V	22	Insurance	5,224	The Orthon Group		5,224		3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 183,132			$ 183,132	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

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15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James J. Nemec	Board Member	Trustee of the	None	None	10	25.00%	Financial	$ 55,556	19-03	1
2			Board and owner					Services			2
3			of Heritage Capital								3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 55,556		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

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B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
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1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

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B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LaSalle Bank		X	Construction Bond	Various	1991	$ 5,800,000	$ 5,800,000	09/06	Various	$ 77,975	1
2	Bank One		X	Construction Bond	Various	1997	1,000,000	592,225	09/03	Various	8,176	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Comerica		X	LOC							76,096	6
7												7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$ 6,800,000	$ 6,392,225			$ 162,247	9
	B. Non-Facility Related*											
10												10
11	Bond Interest - Apt										(8,176)	11
12	Clara Eddy - Unrealized loss										484	12
13	See Supplemental Schedule										15,024	13
14	TOTAL Non-Facility Related						$	$			$ 7,332	14
15	TOTALS (line 9+line14)						$ 6,800,000	$ 6,392,225			$ 169,579	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ NA Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15	Interest on Gift Annuity						$	$			$ 16,746	15
16	Investment Income										(1,722)	16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										15,024	20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	NA	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1998	8
	1999	9
	2000	10
	2001	11
	2002	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Washington And Jane Smith COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0015032

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Washington And Jane Smith COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0015032

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 185,004 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

11248 S. Oakley Avenue - site of future assisted living property (costs adjusted out on page 5)

11365 S. Western Ave - 17 independent living apartments (costs adjusted out on page 5)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		247,516	Pre 1994	$ 649,404	1
2					2
3	TOTALS	247,516		$ 649,404	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	40		1924		$ 70,920	$		$	$	$ 70,920	4
5	57			1928	438,552					438,558	5
6	55			1958	429,080					429,080	6
7	50			1972	1,528,440	43,670		43,670		1,099,688	7
8	77			1992	4,868,578	139,102		139,102		1,530,123	8
	Improvement Type**										
9	Various			1972	307,827		20	-		-	9
10	Various			1974	48,223		20	-		-	10
11	Various			1975	91,428		20	-		-	11
12	Various			1978	205,755		20	-		-	12
13	Various			1980	102,046		20	-		-	13
14	Various			1981	31,819		20	-		-	14
15	Various			1982	53,600		20	-		-	15
16	Various			1983	163,759		20	-		-	16
17	Various			1984	190,740		20	-		-	17
18	Various			1985	26,309		20	-		-	18
19	Various			1987	149,405		20	-		-	19
20	Various			1989	232,022		20	-		-	20
21	Various			1991	1,131,229		20	-		-	21
22	Various			1992	7,248		20	-		-	22
23	Various			1993	77,863		20	-		-	23
24	Various			1994	102,713		20	-		-	24
25	Various			1995	280,978		20	-		-	25
26	Various			1996	71,878		20	-		-	26
27	Various			1997	346,148		20	-		-	27
28	Various			1998	256,549		20	-		-	28
29	Various			1999	21,461		20	-		-	29
30	Various			2000	92,962		20	-		-	30
31								-		-	31
32	RECONCILIATION OF LIMPS DEPRECIATION					195,303		195,303		-	32
33	R&M 2001							1,114	1,114	-	33
34	R&M 2002							1,234	1,234	-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)								68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 11,327,532	$ 378,075		$ 380,423	$ 2,348	$ 3,568,369	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 11,327,532	$ 378,075		$ 380,423	$ 2,348	$ 3,568,369	1
2	Vertical blinds	2001	1,211		20				2
3	Paint three floor corridors	2001	6,240		20				3
4	Paint kitchen	2001	3,535		20				4
5	Asbestos encapsulation	2001	3,410		20				5
6	Replacement door	2001	1,019		20				6
7	Asphalt repair	2001	2,275		20				7
8	Tub supplies	2001	919		20				8
9	Tub supplies	2001	12		20				9
10	Renovations-2nd floor	2001	94		20				10
11	Renovations-2nd floor	2001	1,001		20				11
12	Tub supplies	2001	1,920		20				12
13	Renovations-2nd floor	2001	25,734		20				13
14	Tenant buildout	2001	3,903		20				14
15	Floor covering	2001	1,050		20				15
16	Hydro-flushing of sewers	2001	785		20				16
17	Paint common areas	2001	429		20				17
18	Irrigation system - R&M	2001	665		20				18
19	Paint - R&M	2001	587		20				19
20	Paint - R&M	2001	1,151		20				20
21	Boiler - R&M	2001	704		20				21
22	Shade - R&M	2001	1,037		20				22
23	Carpeting - R&M	2001	3,759		20				23
24	Air conditioning chiller R&M	2001	1,952		20				24
25	Thermostat R&M	2001	783		20				25
26	Waterproofing	2001	1,900		20				26
27	Renovations-2nd floor Beverly	2001	384		20				27
28	Pre-construction Beverly	2001	667		20				28
29	Carpet	2001	4,541		20				29
30	Carpet	2001	4,419		20				30
31	Security camera	2001	1,836		20				31
32	Fireproof file safe	2001	8,119		20				32
33	Smoke detectors	2001	7,791		20				33
34	TOTAL (lines 1 thru 33)		$ 11,421,364	$ 378,075		$ 380,423	$ 2,348	$ 3,568,369	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 11,421,364	$ 378,075		$ 380,423	$ 2,348	$ 3,568,369	1
2	Certification letter for smoke detectors	2001	900		20				2
3	Sealcoat & Parking Lot	2001	3,125		20				3
4	Sewer Improvements	2001	2,434		20				4
5	Sewer Improvements	2001	200		20				5
6	Topography	2001	2,850		20				6
7	Tunnel Roofing	2001	2,800		20				7
8	Kitchen door replaclement	2001	2,350		20				8
9	Painting Hallway & Nursing Station	2001	5,544		20				9
10	Awning for Gregg Entrance	2001	776		20				10
11	Window Blinds	2001	3,327		20				11
12	Paint	2001	2,090		20				12
13	Air Conditioner	2001	298		20				13
14	Water Heater	2001	4,026		20				14
15	Filters	2001	828		20				15
16	Generator Repair	2001	775		20				16
17	Security Key Pad	2001	1,111		20				17
18	Cabling Material & Labor	2001	3,973		20				18
19	Painting	2001	2,396		20				19
20	Carpeting	2001	7,063		20				20
21	Window Shades	2001	1,370		20				21
22	Window Treatment	2001	576		20				22
23	Doors	2001	1,685		20				23
24	AL Dining Room Remodeling	2001	847		20				24
25	Gas Valve Operator	2001	1,383		20				25
26	Storm Damage Repair - Roof & Gutters	2002	28,675		20				26
27	115 V Pump	2002	1,009		20				27
28	Landscape	2002	2,310		20				28
29	Upgrade Fire Safety System	2002	1,645		20				29
30	Painting	2002	12,635		20				30
31	Upgrade Kitchen Wiring for Dishwasher	2002	7,850		20				31
32	Painting & Wall Removal	2002	9,460		20				32
33	Paint	2002	809		20				33
34	TOTAL (lines 1 thru 33)		$ 11,538,484	$ 378,075		$ 380,423	$ 2,348	$ 3,568,369	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 11,538,484	$ 378,075		$ 380,423	$ 2,348	$ 3,568,369	1
2	Generator Fuel Tank & Pump	2002	1,500		20				2
3	Refurbish Oakley Booster Pump	2002	1,401		20				3
4	Paint Stairwells	2002	982		20				4
5	AL Living Room	2002	283		20				5
6	AL Living Room	2002	2,274		20				6
7	AL Living Room - Electrical	2002	1,165		20				7
8	AL Living Room	2002	5,479		20				8
9	AL Living Room - Paint	2002	741		20				9
10	AL Living Room - Countertops	2002	3,065		20				10
11	Laundry AC Unit	2002	1,384	277	20	277			11
12	Common Area Carpet	2002	1,755	351	20	351			12
13	Guardian System Additions	2002	5,915	592	20	592			13
14	Painting - R&M	2002	3,150		20	158	158		14
15	Sewage Pump	2002	720		20				15
16	Flag Pole	2002	644		20				16
17	Valves & Operator	2002	1,299		20				17
18	Morrison Exhaust Fan	2002	899	90	20	90	(0)		18
19	Front Door Replacement	2002	1,600	160	20	160			19
20	Boiler Repairs	2002	1,625	163	20	163			20
21	Painting	2002	1,275	128	20	128			21
22	Morrison Sidewalks	2002	4,795	480	20	480			22
23	Painting	2002	595	60	20	60			23
24	Painting	2002	1,360	136	20	136			24
25	Painting	2002	1,050	105	20	105			25
26	Drapes	2002	256	26	20	26			26
27	Drapes	2002	1,178	118	20	118			27
28	Paint & Supplies	2002	513		20	51	51		28
29	Paint & Supplies	2002	746		20	75	75		29
30	Repair Aurora pump	2002	814		20	81	81		30
31	Heavy duty door	2002	2,009		20	201	201		31
32	Repair gate	2002	500		20	50	50		32
33	Resident room carpeting	2002	1,510		20	151	151		33
34	TOTAL (lines 1 thru 33)		$ 11,590,966	$ 380,761		$ 383,876	$ 3,115	$ 3,568,369	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 11,590,966	$ 380,761		$ 383,876	$ 3,115	$ 3,568,369	1
2	Door locks	2002	528		20	53	53		2
3	Pump repair	2002	847		20	85	85		3
4	Boiler repair	2002	675		20	68	68		4
5	Repair dairy walk-in cooler	2002	1,474		20	147	147		5
6	Boiler Repairs	2003	5,396	540	20	540			6
7	Fire Alarm Panel Repair	2003	1,947	195	20	195			7
8	Painting	2003	3,574	357	20	357			8
9	Repair Morrison Heat Pumps	2003	1,480	148	20	148			9
10	Guardian System Additions	2003	1,205	121	20	121			10
11	Cooler Coolant	2003	1,540	154	20	154			11
12	Dish Sink	2003	1,107	111	20	111			12
13	Turn-on Lawn Sprinkler	2003	896		20	90	90		13
14	Turn-on Lawn Sprinkler	2003	770		20	77	77		14
15	Paint & Supplies	2003	1,273		20	127	127		15
16	Resident room carpeting	2003	798		20	80	80		16
17	Resident room carpeting	2003	506		20	51	51		17
18	Resident room carpeting	2003	644		20	64	64		18
19	Resident room carpeting	2003	1,257		20	126	126		19
20	Replace compressor	2003	1,180		20	119	119		20
21	Repair air conditioning	2003	1,769		20	177	177		21
22	Repair delfield cooler	2003	1,163		20	116	116		22
23	Replace fill valve and drain asse	2003	623		20	62	62		23
24	Drapes	2003	2,296	230	20	230			24
25	Painting North Entrance	2003	1,880	188	20	188			25
26	Painting Reception Areas	2003	1,975	198	20	198			26
27	Door Security - Patio off Main Sitting Room	2003	6,694	669	20	669			27
28	Chimney Work	2003	2,720	272	20	272			28
29	Tuckpointing - North Courtyard Vent	2003	1,380	138	20	138			29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,638,563	$ 384,082		$ 388,639	$ 4,557	$ 3,568,369	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 11,638,563	$ 384,082		$ 388,639	$ 4,557	$ 3,568,369	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,638,563	$ 384,082		$ 388,639	$ 4,557	$ 3,568,369	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 11,638,563	$ 384,082		$ 388,639	$ 4,557	$ 3,568,369	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,638,563	$ 384,082		$ 388,639	$ 4,557	$ 3,568,369	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 11,638,563	$ 384,082		$ 388,639	$ 4,557	$ 3,568,369	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,638,563	$ 384,082		$ 388,639	$ 4,557	$ 3,568,369	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 11,638,563	$ 384,082		$ 388,639	$ 4,557	$ 3,568,369	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,638,563	$ 384,082		$ 388,639	$ 4,557	$ 3,568,369	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 11,638,563	$ 384,082		$ 388,639	$ 4,557	$ 3,568,369	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,638,563	$ 384,082		$ 388,639	$ 4,557	$ 3,568,369	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 11,638,563	$ 384,082		$ 388,639	$ 4,557	$ 3,568,369	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,638,563	$ 384,082		$ 388,639	$ 4,557	$ 3,568,369	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 872,567	$ 76,516	$ 88,407	$ 11,891	10	$	71
72	Current Year Purchases	147,971	14,797	14,797		10		72
73	Fully Depreciated Assets	619,547				10	619,547	73
74								74
75	TOTALS	$ 1,640,085	$ 91,313	$ 103,204	$ 11,891		$ 619,547	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Nursing Facility	1999 Ford Taurus	1999	$ 16,118	$ 1,612	$ 1,612	$	5	$	76
77	Nursing Facility	2002 Pick-up Truck	2002	21,905	2,191	2,191		5		77
78	Nursing Facility	2000 Ford Goshen Bus	2000	45,104	3,007	3,007		5		78
79	Nursing Facility	Bus Improvements	2003	5,461				5		79
80	TOTALS			$ 88,588	$ 6,810	$ 6,810	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 14,016,640	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 482,205	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 498,653	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 16,448	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,187,916	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land Apt	$ 112,500	$	$	86
87	Building Apt	487,975	12,199	79,295	87
88	Building Improv. Apt	119,516	11,273	52,218	88
89	Furniture Apt	30,055	4,553	25,394	89
90	House - Land and Building	321,223	5,932	5,932	90
91	TOTALS	$ 1,071,269	$ 33,957	$ 162,839	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 40,254 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 120,136	$		$ 120,136	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			4,878			4,878	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			155,628			155,628	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				551,335		551,335	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						57,142		57,142	13
14	TOTAL			$		$ 280,642	$ 608,477		$ 889,119	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith **#** 0015032 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 371,023	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	940,004		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	32,986,476		5
6	Prepaid Insurance	23,512		6
7	Other Prepaid Expenses	32,342		7
8	Accounts Receivable (owners or related parties)	12,419,435		8
9	Other(specify):	1,542		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 46,774,334	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	9,232,667		12
13	Land	875,481		13
14	Buildings, at Historical Cost	8,031,190		14
15	Leasehold Improvements, at Historical Cost	3,000,072		15
16	Equipment, at Historical Cost	2,584,051		16
17	Accumulated Depreciation (book methods)	(7,040,028)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	610,187		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 17,293,620	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 64,067,954	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 184,131	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,359		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	307,100		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		210,297		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 717,887	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,392,225		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,392,225	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,110,112	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 56,957,842	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 64,067,954	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 58,735,896	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 58,735,896	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,778,054)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,778,054)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 56,957,842	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,470,001	1
2	Discounts and Allowances for all Levels	(616,346)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,853,655	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	531,504	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 531,504	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	43,226	13
14	Non-Patient Meals	2,671	14
15	Telephone, Television and Radio	404	15
16	Rental of Facility Space		16
17	Sale of Drugs	599,163	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,082	19
20	Radiology and X-Ray		20
21	Other Medical Services	251,467	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 898,013	23
	D. Non-Operating Revenue		
24	Contributions	150,440	24
25	Interest and Other Investment Income***	(531,393)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (380,953)	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	142,834	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 142,834	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,045,053	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,377,197	31
32	Health Care	3,079,282	32
33	General Administration	2,479,724	33
	B. Capital Expense		
34	Ownership	746,831	34
	C. Ancillary Expense		
35	Special Cost Centers	1,088,608	35
36	Provider Participation Fee	51,465	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,823,107	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,778,054)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,778,054)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,710	1,950	$ 66,308	$ 34.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	24,758	26,423	585,574	22.16	3
4	Licensed Practical Nurses	36,451	37,392	469,749	12.56	4
5	Nurse Aides & Orderlies	112,994	120,569	1,229,569	10.20	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,449	5,944	77,852	13.10	8
9	Activity Director	1,943	1,950	32,132	16.48	9
10	Activity Assistants	20,623	21,493	198,338	9.23	10
11	Social Service Workers	5,500	5,850	129,846	22.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	9,048	9,812	129,679	13.22	14
15	Cook Helpers/Assistants	29,706	30,780	272,896	8.87	15
16	Dishwashers	7,972	8,441	89,918	10.65	16
17	Maintenance Workers	24,135	25,848	351,398	13.59	17
18	Housekeepers	14,278	15,310	133,684	8.73	18
19	Laundry	8,516	9,373	80,428	8.58	19
20	Administrator	1,873	1,950	92,625	47.50	20
21	Assistant Administrator	1,800	1,950	48,017	24.62	21
22	Other Administrative					22
23	Office Manager	1,898	1,950	63,076	32.35	23
24	Clerical	23,204	24,185	359,538	14.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,234	2,389	29,201	12.22	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	9,193	9,871	117,249	11.88	33
34	TOTAL (lines 1 - 33)	343,285	363,430	$ 4,557,077 *	$ 12.54	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	11,600	09-03	36
37	Medical Records Consultant	Monthly	4,128	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,406	10-03	39
40	Physical Therapy Consultant	59	2,966	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,794	11-03	44
45	Social Service Consultant	43	2,363	12-03	45
46	Other(specify)				46
47	Chaplain	57	2,129	12-03	47
48	Physical Fitness Program	1,573	34,615	11-03	48
49	TOTAL (lines 35 - 48)	1,732	$ 64,001		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	449	$ 18,507	10-03	50
51	Licensed Practical Nurses	893	31,195	10-03	51
52	Nurse Aides	16	295	10-03	52
53	TOTAL (lines 50 - 52)	1,358	$ 49,997		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Carroll	Executive Director	0	$ 92,625
Kevin McGee	Assoc Exec Dir	0	48,018
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 140,643

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	Accounting	$ 25,625
Ken Jellema	Accounting	2,578
Desmond & Ahern	Accounting	9,909
Project Leaders Associates	Computer Services	270
Industrial Appraisal Company	Real Estate Appraisal	600
Michael Best & Fredrick	Legal	1,273
Winston & Strawn	Legal	4,576
Quarles & Brady	Legal	57,098
Ameripay	Payroll Service	8,429
Pinnacle	Computer Services	2,049
Healthmedx	Computer Services	577
See Supplemetal Schedule		55,556
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 168,540

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 143,021
Unemployment Compensation Insurance	25,507
FICA Taxes	335,822
Employee Health Insurance	322,328
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Meals	21,900
Employee Special Functions/Events	8,017
Pension Expense	250,721
Life/Disability Insurance	9,373
Misc employee benefits	13,504
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,130,193

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,704
Health Care Worker Background Check	1,700
(Indicate # of checks performed 243)	
Dues/Subsciptions	2,303
Advertising	6,317
Promotions	1,797
Less: Public Relations Expense	(1,797)
Non-allowable advertising	(5,801)
Yellow page advertising	(516)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,707

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	887
Seminar Expense	4,922
Entertainment Expense	( )
(agree to Sch. V,	
TOTAL line 24, col. 8)	$ 5,809

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington And Jane Smith # 0015032 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **51,482** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **51,465**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **21,900** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,671**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **FR&R** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.